



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA MEDICAL CENTER HOSPITAL
4301 VISTA ROAD
PASADENA TEXAS 77504

Respondent Name

FACILITY INSURANCE CORP

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-05-8105-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Dated June 2, 2005: "The Carrier did not provide a proper explanation in conjunction with the 'F, M, G, and N' payment exception codes as required by the TWCC rules and Commission instructions." "The Carrier is allowed to deduct any personal items and may only deduct non-documented services and items and services, which are not related to the compensable injury. At that time, if the total audited charges for *the entire admission* are below \$40,000, the Carrier may reimburse at a 'per diem' rate for the hospital services. However, if the total audited charges for *the entire admission* are at or above \$40,000, the Carrier shall reimburse using the 'Stop-Loss Reimbursement Factor' (SLRF). The SLRF of 75% is applied to the 'entire admission'." "In this instance, the audited charges that remained in dispute after the last bill review by the insurance carrier were \$170,734.55. The prior amounts paid by the carrier were \$14,012.52. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of **\$114,038.39, plus interest.**"

Requestor's Supplemental Position Summary Dated October 28, 2011: "Please allow this letter to serve as a supplemental statement to Vista's originally submitted request for dispute resolution in consideration of the Texas Third Court of Appeal's Final Judgment...The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons...The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons..."

Amount in Dispute: \$114,038.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated May 31, 2005: "The Requestor asserts it is entitled to reimbursement in the amount of \$128,050.91, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement..."

Respondent's Supplemental Position Summary Dated June 22, 2005: "Carrier has previously responded to this dispute... Carrier maintains its position as outlined in the original response."

Respondent's Supplemental Position Summary Dated June 23, 2005: "The Requestor asserts it is entitled to reimbursement in the amount of \$128,050.91, which is 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement..."

Respondent's Supplemental Position Summary Dated September 8, 2011: "Respondent submits this Respondent's Post-Appeal Supplemental Response as a response to and incorporation of the Third Court of Appeals Mandate in Cause No. 03-07-00682-CV...Based upon Respondent's initial and all supplemental responses, and in accordance with the Division's obligation to adjudicate the payment, in accordance with the Labor Code and Division rules, Requestor has failed to sustain its burden of proving entitlement to the stop-loss exception. The Division must conclude that payment should be awarded in accordance with the general *per diem* payment in accordance with 28 Texas Administrative Code §134.401 (repealed)..."

Responses Submitted by: Flahive, Ogden & Latson, 505 West 12th Street, Austin, Texas 78701

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
June 9, 2004 through June 14, 2004	Inpatient Hospital Services	\$114,038.39	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Former 28 Texas Administrative Code §133.304, 25 Texas Register 2115, applicable to dates of service on or after July 15, 2000, sets out the procedures for medical payments and denials.
2. Former 28 Texas Administrative Code §133.305, 27 Texas Register 12282, effective January 1, 2003, sets out general provisions for medical dispute resolution.
3. Former 28 Texas Administrative Code §133.307, 27 Texas Register 12282, applicable to requests filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
4. Former 28 Texas Administrative Code §134.401, 22 Texas Register 6264, effective August 1, 1997, sets out the fee guidelines for inpatient services rendered in an acute care hospital.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 18, 2004

- F-Payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital Fee Guideline.
- M-Payment reduced according to fair and reasonable.
- G-Payment for these services is included in the Per Diem amount.
- N-Since Forte's has not received a response from our telephone, fax, and/or email request(s) for additional documentation in the past 14 days we are denying payment for the applicable services. Please submit the requested information.
- N-Forte' routinely requests an invoice for all supplies with a billed amount of \$50.00 or greater. Forte' has contacted you by telephone, fax, and/or email to obtain the information necessary to process this medical bill. Since you have not responded to our request Forte' is denying payment for these services at this time.
- Please see attached letter. It does not appear that any invoices for the implantables were submitted.

Explanation of benefits dated October 15, 2004

- F-Payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital Fee Guideline.
- M-Payment reduced according to fair and reasonable.
- O-Previously recommended amount has not been changed.
- G-Payment for these services is included in the Per Diem amount.
- F-Implantables reimbursed an Cost + 10%.
- S-Previously recommended amount has been amended as indicated.
- Reimbursement for the implantables was based on the manufacturer's invoice supplied:
Neurovision Module \$1270.00 + \$127.00 = \$1397.00
Screw \$27.00 + \$2.70= \$29.70 X 4 = \$118.80

CorticeL \$5350.00 + \$535.00 = \$5885.00

Washer \$19.75 + \$1.97 = \$21.72

Total = \$8422.52

Issues

1. Did the respondent provide sufficient explanation for denial of the disputed services?
2. Did the audited charges exceed \$40,000.00?
3. Did the admission in dispute involve unusually extensive services?
4. Did the admission in dispute involve unusually costly services?
5. Is the requestor entitled to additional reimbursement?

Findings

Division rule at 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including a statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of Division rule at 28 Texas Administrative Code §134.401, titled *Acute Care Inpatient Hospital Fee Guideline*, effective August 1, 1997, 22 Texas Register 6264. The Austin’s Third Court of Appeals November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) addressed a challenge to the interpretation of 28 Texas Administrative Code §134.401. The Court concluded that “to be eligible for reimbursement under the Stop-Loss Exception, a hospital must demonstrate that the total audited charges exceed \$40,000 and that an admission involved unusually costly and unusually extensive services.” On August 10, 2011, both the requestor and respondent in this case were notified via form letter that the mandate for the decision cited above was issued on January 19, 2011. Each was given the opportunity to supplement their original MDR submission, position or response as applicable. The Division received supplemental information from the respondent on September 8, 2011 and then received supplemental information from the requestor on October 28, 2011. The supplemental information was shared among the parties as appropriate. The documentation filed by the requestor and respondent to date will be considered in determining whether the admission in dispute is eligible for reimbursement under the stop-loss method of payment. Consistent with the Austin’s Third Court of Appeals November 13, 2008 opinion, the Division will address whether the total audited charges **in this case** exceed \$40,000; whether the admission and disputed services in this case are unusually extensive; and whether the admission and disputed services in this case are unusually costly. 28 Texas Administrative Code §134.401(c)(2)(C) states, in pertinent part that “Independent reimbursement is allowed on a case-by-case basis if the particular case exceeds the stop-loss threshold as described in paragraph (6) of this subsection...” 28 Texas Administrative Code §134.401(c) (6) puts forth the requirements to meet those three factors.

1. The requestor in its position statement asserts that “The Carrier did not provide a proper explanation in conjunction with the ‘F, M, G, and N’ payment exception codes as required by the TWCC rules and Commission instructions.” 28 Texas Administrative Code §133.304(c), 25 Texas Register 2128, effective July 15, 2000, states, in pertinent part, that

“At the time an insurance carrier makes payment or denies payment on a medical bill, the insurance carrier shall send, in the form and manner prescribed by the Commission, the explanation of benefits to the appropriate parties. The explanation of benefits shall include the correct payment exception codes required by the Commission’s instructions, and shall provide sufficient explanation to allow the sender to understand the reason(s) for the insurance carrier’s action(s). A generic statement that simply states a conclusion such as ‘not sufficiently documented’ or other similar phrases with no further description of the reason for the reduction or denial of payment does not satisfy the requirements of this section.”

Review of the submitted documentation finds that the explanation of benefits dated August 18, 2004 and October 15, 2004 were issued using the division-approved form TWCC 62 and noted payment exception codes” F-Payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital Fee Guideline,” “M-Payment reduced according to fair and reasonable,” “G-Payment for these services is included in the Per Diem amount,” “N-Since Forte’s has not received a response from our telephone, fax, and/or email request(s) for additional documentation in the past 14 days we are denying payment for the applicable services. Please submit the requested information,” “N-Forte’ routinely requests an invoice for all supplies with a billed amount of \$50.00 or greater. Forte’ has contacted you by telephone, fax, and/or email to obtain the information necessary to process this medical bill. Since you have not responded to our request Forte’ is denying payment for these services at this time,” “O-Previously recommended amount has not been

changed,” “F-Implantables reimbursed an Cost + 10%,” and “S-Previously recommended amount has been amended as indicated.” These payment exception codes support an explanation for the reduction of reimbursement based on former 28 Texas Administrative Code §134.401, and therefore support a reduction of the reimbursement amount from the requested stop-loss exception payment reimbursement methodology to the standard per diem methodology amount. The Division finds that the explanation of benefits was sent in the prescribed form and manner and included the correct payment exception codes as required by Division instructions. The Division further finds that the explanation of benefits provided sufficient explanation to allow the provider to understand the reason(s) for the insurance carrier's action(s). The Division therefore concludes that the insurance carrier has met the requirements of §133.304(c).

2. 28 Texas Administrative Code §134.401(c)(6)(A)(i) states “...to be eligible for stop-loss payment the total audited charges for a hospital admission must exceed \$40,000, the minimum stop-loss threshold..” Furthermore, (A) (v) of that same section states “...Audited charges are those which remain after a bill review by the insurance carrier has been performed...” Review of the explanation of benefits issued by the carrier on August 18, 2004 and October 15, 2004 finds that the carrier did not deduct any charges in accordance with §134.401(c)(6)(A)(v), therefore the audited charges equal \$170,734.55. The Division concludes that the total audited charges exceed \$40,000.
3. The requestor in its original position statement stated, in pertinent part “...if the total audited charges for *the entire admission* are at or above \$40,000, the Carrier shall reimburse using the ‘Stop-Loss Reimbursement Factor’ (SLRF). The SLRF of 75% is applied to the ‘entire admission’.” As noted above, the Austin Third Court of Appeals November 13, 2008 opinion in *Texas Mutual Insurance Company v. Vista Community Medical Center, LLP*, 275 South Western Reporter Third 538, 550 (Texas Appeals – Austin 2008, petition denied) rendered judgment to the contrary. In its supplemental position statement dated October 28, 2011 the requestor considered the Court’s final judgment and opined on both rule requirements. In regards to whether the services were unusually extensive, the Third Court of Appeal’s November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually extensive services. Rule §134.401(c)(2)(C) allows for payment under the stop-loss exception on a case-by-case basis only if the particular case exceeds the stop-loss threshold as described in paragraph (6). Paragraph (6)(A)(ii) states that “This stop-loss threshold is established to ensure compensation for unusually extensive services required during an admission.” The requestor’s supplemental position statement asserts that:

“The medical records on file with MDR show this admission to be a complex spine surgery which is unusually extensive for at least three reasons; first, this type of surgery is unusually extensive when compared to all surgeries performed on workers’ compensation patients in that only 19% of such surgeries involved operations on the spine; second, this type of surgery requires additional, trained nursing staff and specialized equipment (such as the operating table) thereby making the hospital services unusually extensive; and third, the median length of stay (“LOS”) for workers’ compensation inpatient admission is three days whereas the length of stay for this admission exceeds the median LOS. Finally, any evidence of comorbidities, which should be considered, is part of the medical records, which have been previously filed.”

The requestor’s categorization of spinal surgeries presupposes that all spinal surgeries are unusually extensive for the specified reasons. The requestor did not submit documentation to support the reasons asserted, nor did the requestor point to any sources for the information presented. The reasons stated are therefore not demonstrated. Additionally, the requestor’s position that all spinal surgeries are unusually extensive does not satisfy §134.401(c)(2)(C) which requires application of the stop-loss exception on a case-by-case basis. The Third Court of Appeals November 13, 2008 opinion affirmed this, stating “The rule further states that independent reimbursement under the Stop-Loss Exception will be ‘allowed on a case-by-case basis.’ *Id.* §134.401(c)(2)(C). This language suggests that the Stop-Loss Exception was meant to apply on a case-by-case basis in relatively few cases.” The requestors position that all spine surgeries are unusually extensive fails to meet the requirements of §134.401(c)(2)(C) because the particulars of the services in dispute are not discussed, nor does the requestor demonstrate how the services in dispute were unusually extensive in relation to similar spinal surgery services or admissions. For the reasons stated, the Division finds that the requestor failed to demonstrate that the admission and services in dispute are unusually extensive.

4. In regards to whether the services were unusually costly, the Third Court of Appeal’s November 13, 2008 opinion concluded that in order to be eligible for reimbursement under the stop-loss exception, a hospital must demonstrate that an admission involved unusually costly services. 28 Texas Administrative Code §134.401(c)(6) states that “Stop-loss is an independent reimbursement methodology established to ensure fair and reasonable compensation to the hospital for unusually costly services rendered during treatment to an injured worker.” The requestor’s supplemental position statement asserts that:

“The medical and billing records on file with MDR also show that this admission was unusually costly for two reasons: first the median charge for all workers’ compensation inpatient surgeries is \$23,187; the median charge for workers’ compensation surgeries of this type is \$39,000; therefore the audited billed charges for this surgery substantially exceed not only the median charges, but also the \$40,000 stop-loss threshold; second, as mentioned in the preceding paragraph, in order for this surgery to be performed, specialized equipment and specially trained, extra nursing staff were required, thereby adding substantially to the cost of surgery in comparison to other types of surgeries.”

The requestor asserts that because the **billed charges** exceed the stop-loss threshold, the admission in this case is unusually costly. The Division notes that audited charges are addressed as a separate and distinct factor described in 28 Texas Administrative Code §134.401(c)(6)(A)(i). Billed charges for services do not represent the cost of providing those services, and no such relation has been established in the instant case. The requestor fails to demonstrate that the **costs** associated with the services in dispute are unusual when compared to similar spinal surgery services or admissions. For that reason, the division rejects the requestor’s position that the admission is unusually costly based on the mere fact that the billed or audited charges “substantially” exceed \$40,000. The requestor additionally asserts that certain resources that are used for the types of surgeries associated with the admission in dispute (i.e. specialized equipment and specially-trained, extra nursing staff) added substantially to the cost of the admission. The requestor does not list or quantify the costs associated with these unusual resources in relation to the disputed services, nor does the requestor provide documentation to support a reasonable comparison between the resources required for both types of surgeries, and therefore fails to demonstrate that the resources used in this particular admission are unusually costly when compared to resources used in “other types of surgeries.” As noted above, the Third Court of Appeals November 13, 2008 opinion stated that “...the Stop-Loss Exception was meant to apply on a case-by-case basis in a relatively few cases.” The Division concludes that the requestor failed to demonstrate that the specific services in this dispute were unusually costly when compared to similar spinal surgery services or admissions.

5. For the reasons stated above the services in dispute are not eligible for the stop-loss method of reimbursement. Consequently, 28 Texas Administrative Code §134.401(c) (1) applies. Review of the submitted documentation finds that the services provided were surgical; therefore the standard per diem amount of \$1,118.00 per day applies. Division rule at 28 Texas Administrative Code §134.401(c)(3)(ii) states, in pertinent part, that “(ii) The applicable Workers' Compensation Standard Per Diem Amount (SPDA) is multiplied by the length of stay (LOS) for admission...” In addition to the per diem amount, 28 Texas Administrative Code §134.401(c)(4), allows for additional reimbursement for certain items. This additional reimbursement applies only to bills that do not reach the stop-loss threshold described in subsection (c)(6) of this section. The length of stay is 5 days. The surgical per diem rate of \$1,118 multiplied by the length of stay of 5 days results in an allowable amount of \$5,590.00.

28 Texas Administrative Code §134.401(c)(4)(A), states “When medically necessary the following services indicated by revenue codes shall be reimbursed at cost to the hospital plus 10%: (i) Implantables (revenue codes 275, 276, and 278), and (ii) Orthotics and prosthetics (revenue code 274).” A review of the submitted hospital bill finds that the requestor billed \$52,722.25 for revenue code 278-Implants. A review of the submitted EOB indicates that the respondent paid \$8422.52 based upon reason codes “F-Payment based on the assigned Per Diem amount per the 1997 Texas Inpatient Hospital Fee Guideline,” “M-Payment reduced according to fair and reasonable,” “S-Previously recommended amount has been amended as indicated,” and “O-Previously recommended amount has not been changed.”

The Division finds the total allowable for the implants billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Invoice Cost	Cost + 10%
Rod	2	Invoice not submitted	Unknown
Neuro Vision Module	1	\$1,270.00	$\$1,270.00 + \$127.00 = \$1,397.00$
Screw Multi	4	\$27.00	$\$27.00 + \$2.70 = \$29.70$ $\times 4 = \$118.80$
DBM100 Accell	2	Invoice not submitted	Unknown
Cortical Cancellous	1	Invoice not submitted	Unknown
Screw Set	4	Invoice not submitted	Unknown
Central Venous Catheter	1	Invoice not submitted	Unknown
Washer	1	\$19.75	$\$19.75 + \$1.97 = \$21.72$

Bone Graft Cortek	1	\$5,350.00	\$5,350.00 + \$535.00 = \$5,885.00
Screw Synthes	1	Invoice not submitted	Unknown
TOTAL DUE			\$7,422.52

28 Texas Administrative Code §134.401(c)(4)(B), states "When medically necessary the following services indicated by revenue codes shall be reimbursed at a fair and reasonable rate: (iv) Blood (revenue codes 380-399)." A review of the submitted hospital bill finds that the requestor billed \$598.00 for revenue code 391- Blood Storage/Blood Processing. The respondent reimbursed the requester \$0.00 for revenue code 391 based upon "M-Payment reduced according to fair and reasonable," and "O-Previously recommended amount has not been changed." 28 Texas Administrative Code §133.307(g)(3)(D), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that the documentation submitted by the requestor does not demonstrate or justify that the amount sought for revenue code 391 would be a fair and reasonable rate of reimbursement. Additional payment cannot be recommended.

Based upon the per diem reimbursement methodology and submitted documentation, the total allowable is \$13,012.52 (\$5,590.00 + \$7,422.52). Review of the submitted documentation finds that the respondent issued payment in the amount of \$14,012.52 for the surgical days and implants. No additional amount is recommended.

Conclusion

The submitted documentation does not support the reimbursement amount sought by the requestor. The requestor in this case demonstrated that the audited charges exceed \$40,000, but failed to demonstrate that the disputed inpatient hospital admission involved unusually costly services, and failed to demonstrate that the services in dispute were unusually extensive. The requestor further failed to establish that additional payment is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	4/2/2012 _____ Date
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_____ Signature	_____ Health Care Business Management Director	4/2/2012 _____ Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.